network
NETWORK 20 NOVEMBER 2007

Clinical guidance special edition

The National Treatment Agency for Substance Misuse (NTA) is pleased to be supporting the publication of this special edition of SMMGP's Network newsletter, covering the 2007 Clinical Guidelines and NICE suite of drug treatment clinical guidance published this year. It forms an important part of the package of guidance and support that the NTA, SMMGP, RCGP and others will be providing to those involved in drug treatment over the coming months. The NTA is grateful to SMMGP staff and members for the hard work they have put into developing it.

GPs and their primary care colleagues have played a vital role in helping to expand drug treatment and its quality. In further building on this success the challenge for primary care – and its commissioners – is threefold:

- to expand the numbers of patients receiving treatment in primary care settings
- to encourage all GPs providing drug treatment to be active members of local treatment systems rather than individual practices treating drug misusers in isolation
- to ensure clinical practice is in line with the new guidelines

Drug misusers have a wide range of needs and, as the 2007 Clinical Guidelines say, "It is seldom the case that one clinician will be able to meet these needs in isolation." Primary care is used to working with other health and social care professionals to meet the needs of its patients and drug misuse is no different in needing professionals to work together to meet needs. Most primary care-based drug treatment is now well-integrated into local drug treatment systems but we think much is still outside local or national enhanced schemes (LES or NES) or what would once have been called formal shared care arrangements. NTA annual drug treatment plans 07/08 tell us that, on average, only 35% of GPs in an area provide treatment within a shared care arrangement and a further 6% prescribe to drug misusers in a commissioned service model outside shared care. There is considerable scope both to increase the number of GPs providing drug treatment and for primary care to be better integrated into drug treatment systems.

There have been great improvements in the quality and consistency of drug treatment and the publication of such a wealth of evidence-based guidance provides a real opportunity to make sure all drug treatment is effective and in line with best practice. As GPs know well, drug misusers often have a complex range of needs. The 2007 guidelines stress that substitute prescribing alone is not enough to deal with those needs and "Treatment for drug misuse should always involve a psychosocial component". For some primary care based drug treatment providing psychosocial interventions may be a challenge – particularly in busy GP practices. This is one reason why GPs are encouraged to work in partnership with other local drug treatment providers.

Improvements in clinical governance across the drug treatment sector will help ensure compliance with the guidance. The NTA will

be asking providers to review their practice against the clinical guidance and plan improvements where necessary. We will also be asking commissioners to support local services in the implementation of the new suite of clinical guidelines.

The NTA is also pleased to be able to work with the RCGP to develop other support for primary care including:

- updates to RCGP Part 1 and 2 Certificates in the Management of Drug Misuse
- CPD events for primary care staff
- revisions to the highly-valued range of RCGP guidance on drug treatment

Finally, we are aware that the articles in this newsletter represent a range of expert views. In some cases, the NTA may not agree with everything said but we welcome the opportunity to encourage debate about how to provide the very best treatment for this group of patients. We look forward to working with you, the RCGP and SMMGP in our mutual goal to provide high quality drug treatment.

Annette Dale-Perera

Director of Quality, NTA

In this issue

We hope you enjoy this special edition.

Editor

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

Editorial

We are excited to present a Special Edition of Network. This edition has been funded by the National Treatment Agency for Substance Misuse (NTA) and has been issued in response to the publication of a plethora of important and influential guidelines and appraisal documents from the National Institute for Health and Clinical Excellence (NICE) and the Department of Health and devolved administrations during the course of this year. This issue should quench the thirst of even the most heavily guideline dependent!

- **Drug misuse and dependence: UK guidelines on clinical management** Department of Health and devolved adminstrations (September 2007)
- **Methadone and buprenorphine for the management of opioid dependence** NICE technology appraisal 114 (January 2007)
- **Naltrexone for the management of opioid dependence** NICE technology appraisal 115 (January 2007)
- **Drug misuse: psychosocial interventions** NICE clinical guideline 51 (July 2007)
- **Drug misuse: opioid detoxification** NICE clinical guideline 52 (July 2007)
- **Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people** NICE public health intervention guidance 4 (March 2007)

The timing of the publication of the updated *2007 Clinical Guidelines* was not an accident. These were timed so that they could take account of and include the recommendations of the NICE publications. This edition will provide you with summaries of the key points of the documents, together with comments and views from SMMGP and practitioners and patients in the drugs field, some of whom were involved in helping to write the documents; we hope this will help to give you some understanding of the guidance, how it needs to be implemented, and how it may impact on your work.

We have also sought the views of key stakeholders in the field as to how the *2007 Clinical Guidelines* may affect drug treatment in the future. The most noticeable change from the 1999 guidelines lies in the range of topics included, such as child protection, psychosocial interventions and the recognition of the need for multidisciplinary working. Certainly treatment is much, much more than a script, and this is recognised.

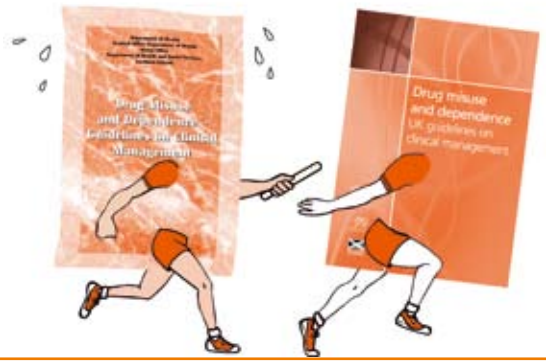
There are interesting and varied points of view on the *2007 Clinical Guidelines*, although one thing all commentators agree on is that they reflect the enormous progress that has been made in the treatment of drug dependency. We also reflect how there is still much to do in continuing to improve services for drug users in this Special Edition.

There is little direct reference to primary care within the *2007 Clinical Guidelines* but this seems to be because within a mature, integrated system there is no need to refer to its core components directly; an emphasis which seems very positive to us. We welcome the fact that the rather restrictive previous single definition of 'shared care' is not used, as we do the acknowledgement that GPs can be specialists in this field, and that practitioners other than doctors can be involved in prescribing. The emphasis on the need for a range of practitioners to deliver optimal care is very refreshing. It is a document that reflects how far the system has matured and improved.

We would like to thank the NTA for their considerable support and advice in producing this edition (in particular Steve Taylor for work beyond the call of duty), and also NICE for their valuable input.

And don't forget that the NTA and NICE are holding a series of events across England to inform you about all the new clinical guidance. For more details see the back page.

Enjoy this issue! **Kate Halliday**



The new 2007 orange guidelines: an overview

Jenny Keen gives a powerful description of how the 2007 Clinical Guidelines reflect the advances in drug treatment since the 1999 Clinical Guidelines were written. The question is no longer whether to treat drug users, but rather how we can improve the quality of the treatment we provide. The 2007 Clinical Guidelines firmly establish maintenance prescribing as the norm, multi-disciplinary working as essential, and place an increased importance on the needs of the children of drug users. Ed.

This is the third set of national clinical guidelines to be produced under the Chairmanship of Professor John Strang, and like its predecessors in 1991 and 1999 this document is as much a mirror of the times as a set of clinical guidance. When reviewing the 1999 guidelines I wrote that they represented "a serious attempt to bring the evidence base into practice and to standardise treatment for drug misuse"[1], which was essential if drug misuse treatment was to be brought into the mainstream. A glance at the revised 2007 version of the guidelines is enough to see how far we have moved on since 1999.

There is no longer any question of establishing drug misuse treatment as part of the mainstream; that battle has already been won. The new guidelines no longer seek to establish the respectability of drug treatment and to outlaw mavericks, nor are they likely to be especially controversial. Instead they represent a mature attempt to engage with what is now a broad multi-professional field, which presents the clinician with complex problems equally likely to derive from the intricacies of multi-agency working as from the drug interactions of methadone. If the new guidelines document seems to cover ground way beyond the purely clinical, this is because it has recognised the need to address these issues head on.

The 1999 guidelines were "for all doctors". The 2007 guidelines address "clinicians" in recognition of the broad range of professionals who are now involved in the clinical care of drug users, and the expansion through supplementary and independent prescribing of those able to prescribe for drug users. Both documents are concerned with delineating the responsibilities of the different individuals in a multi-disciplinary team, but the new guidelines reflect the changed environment in that they address in detail issues such as clinical governance, competencies and training by reference to a wide range of supporting documentation not specific to doctors, but for other prescribers and professionals in the field.

For the first time there is also an attempt to engage with the content of psychosocial interventions and key working and a genuine emphasis on the importance of these interventions. It may be for the next set of national guidelines to look at increased standardisation of practice across this part of the field.

Another reflection of the changed environment is the raised level of prior knowledge expected of the 2007 reader. The 1999 guidelines, whilst aimed at trained doctors, nevertheless felt the need to devote a whole paragraph to recognition of the symptoms and signs of opiate withdrawal. Since 1999 the Royal College of General Practitioners has developed its Part I and Part II Certificate training programmes in the treatment of drug misuse and in which thousands of GPs have taken part. In 2007 it is now possible to assume a basic level of knowledge and many of the basic text book aspects of the 1999 guidelines have been omitted to make way for a more detailed consideration of the more complex aspects of the care of drug users including people in prison, older drug users and aspects of pain management.

Philosophically, too it is clear that battles have been won and left behind. The 1999 guidelines did not include a chapter on maintenance prescribing and the topic was addressed only as the fourth subsection in a chapter entitled "Dose Reduction Regimens". It was felt necessary to defend maintenance treatments with quotations from the 1993 ACMD report [2] and the 1996 Task Force [3]. In contrast the whole thrust of the 2007 guidelines is towards harm reduction in its very broadest sense, with maintenance prescribing as a key element in reducing deaths and promoting good health.

It is almost certainly the case that the 1999 guidelines played a key role in defining and developing treatment services for drug users including the concepts of practitioners with a special interest and shared care working. They have also almost certainly had a considerable effect on prescribing practices. The period since 1999 has seen a huge expansion in the number of drug users who enter prescribed treatment, whilst drug related deaths have fallen over the same time frame. **It has been the task of the 2007 working group to develop guidelines for a changed world in which the struggles of 1999 are taken for granted, and where 'how best to treat drug users' has replaced 'whether to treat drug users' as the key question.**

The new guidelines have taken this on board, not least by embracing and utilising the four NICE guidance documents which have been produced almost concurrently in the drug misuse field and by commissioning evidence reviews on easy-to-ignore topics such as drugs and driving. Buprenorphine, hardly mentioned in 1999, has claimed its place alongside methadone and newer developments including suboxone and the contentious issue of cardiac monitoring are introduced. The complex issues raised by increasingly frequent joint working with criminal justice agencies are also addressed.

If one issue has climbed the agenda significantly more than any others, it must be child protection which is referred to time and again in the 2007 guidelines and it may be this which finally has the greatest impact on practice within treatment services country wide. The new guidelines state that "clinicians have an individual responsibility to the children of their patients". Many services had already recognised the implications of the ACMD hidden harm report [4], but never before have the needs of children in drug using families been raised so high on the list of priorities for those responsible for treating their parents.

The Orange Guidelines have traditionally been unlike many other sets of clinical guidelines in that they do not confine themselves strictly to evidence based assertions and do not make any attempt at formal evaluation of the weight of the evidence behind each recommendation. In some respects this is their strength, as they are able to represent a picture of "best clinical practice" as agreed by a group of clinicians with the aid of others including policy makers, service users and their relatives. Increasingly the new guidelines also refer outwards to publications from organisations such as the government, the GMC and the Royal Colleges on issues where there is common ground with other clinical areas or which have been covered in depth elsewhere.

The 2007 guidelines recognise that the treatment of drug users has developed to a more mature and complex level. They reflect the fact that drug misuse treatment is now firmly in the mainstream. In eight years' time, the total assimilation of drug misuse treatment into every aspect of treatment provision may render a further document of this kind unnecessary. Until then, these guidelines will, like their predecessors, both reflect and shape our treatment of drug using patients.

Dr Jenny Keen
Clinical Director, Primary Care Drugs Services, Derby
RCGP Substance Misuse Unit Regional Lead Clinician

References

1 Jenny Keen *Managing Drug Users in general Practice* BMJ 1999;318:1503-1504
2 Advisory Council on the Misuse of Drugs *AIDS and Drug Misuse Update.* Department of Health HMSO.1993
3 Department of Health *The task force to review services for drug misusers* 1996
4 Advisory Council on the Misuse of Drugs *Hidden Harm* Department of Health 2003

The status of the 2007 Clinical Guidelines

Here is a summary of the status of the 2007 Clinical Guidelines. Ed.

The 2007 guidelines state:

"The 2007 Clinical Guidelines replace the previous 1999 Clinical Guidelines. They have no specific statutory status. However, any clinician not fulfilling the standards and quality of care in the appropriate treatment of drug misusers as set out in these guidelines will have this taken into account if, for any reason, their performance in this clinical area is assessed"

They also quote **The General Medical Council**, who state (GMC, 2006):

- "You should be familiar with relevant guidelines and developments that affect your work."
- "You must keep up to date with, and adhere to, the laws and codes of practice relevant to your work".
- "You must provide effective treatments based on the best available evidence."

They also have a status within **Standards For Better Health** under core standard C5 as 'nationally agreed guidance' which health care organisations must take into account when planning and delivering treatment and care (for more information on Standards For Better Health, see page 11).

Key points from Drug misuse and dependence: UK guidelines on clinical management (September 2007)

We have collated the key points from the 2007 Clinical Guidelines for a quick reference guide for you- but the full text is definitely worth a read! Ed.

Chapter 1. Introduction

- A range of drug misuse treatments have been found to be effective in reducing harm to individual drug misusers, their children and families and local communities.
- Current levels of mortality and morbidity among drug misusers remain a concern (particularly due to overdose and blood-borne virus infections).
- Substantial numbers are affected by drug misuse across the UK. Many of these could benefit from drug treatment, which has been increased substantially over the last decade.

Chapter 2. Clinical governance

- Clinicians working with drug misusers must be appropriately competent, trained and supervised.
- Effective, safe and responsive services for drug misusers will usually involve clinicians working together and with others in teams in primary care, in secondary care or across both.
- The setting in which health professionals work in treating drug misusers will affect the clinical governance mechanisms that need to be in place. Those working in relative isolation must ensure they have an opportunity to discuss and review their work with colleagues in the field, to maintain good and up-to-date practice.
- Services should be provided consistent with national guidance and principles, and in line with the evidence base.
- Policy and statutory frameworks for providing substance misuse treatment to those under 18 years of age are often different from adults and different approaches are required from clinicians.
- The expansion of non-medical prescribing has implications for drug misuse treatment and care and clinical governance.
- A timely and regular audit and review cycle should be in place.
- Information governance policies and practice are critical, including confidentiality and information sharing. They should specifically include guidance for clinicians working with drug-misusing parents.
- Patients must be involved in their own treatment and should be involved in planning, developing, designing and delivering local drug treatment services, as far as their competence and interests allow.
- Families and carers of drug misusers are both an important resource in treating drug misusers and often in need of support for themselves. Carers of adults can be involved in patients' treatment, usually with the patients' consent, although there may be an obligation to involve the carers of young people in their treatment.

Chapter 3. Essential elements of treatment provision

- The needs of all drug misusers should be assessed across the four domains of drug and alcohol misuse, health, social functioning and criminal involvement.
- Risks to dependent children should be assessed for all drug-using parents.
- All drug misusers entering structured treatment should have a care or treatment plan which is regularly reviewed.
- Drug misuse treatment involves a range of interventions, not just prescribing.
- A named individual should manage and deliver aspects of the patient's care or treatment plan.
- Drug testing can be a useful tool in assessment and in monitoring compliance and outcomes of treatment.

Chapter 4. Psychosocial components of treatment

- Treatment for drug misuse should always involve a psychosocial component.
- Keyworking is a basic delivery mechanism for a range of key components including the review of care or treatment plans and goals, provision of drug-related advice and information, harm reduction interventions, and interventions to increase motivation and prevent relapse. Help to address social problems, for example housing and employment, is also important.
- A good therapeutic alliance is crucial to the delivery of any treatment intervention, especially a psychosocial one.
- Discrete formal psychosocial interventions may be provided in addition to keyworking. These should be targeted to addressing assessed need.
- Discrete formal psychosocial interventions may be provided either to treat drug misuse related problems, such as cocaine misuse, or to address common associated or co-occurring mental disorders such as depression or anxiety.
- Psychosocial interventions can be delivered alongside pharmacological interventions or alone, depending on assessed need and the goals of treatment.
- Psychosocial interventions are the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens.
- Self-help and mutual aid approaches, especially 12-Step, have been found to be highly effective for some individuals and patients seeking abstinence should be signposted to them.

- There is a strong evidence base for contingency management (CM) and family and couples interventions. Neither is commonly used in the UK. Clinicians and services will need to evaluate these approaches, and the training and support needed to provide them, before they can be implemented.

Chapter 5. Pharmacological interventions

- Methadone or buprenorphine, used at the optimal dose range, are effective medicines for maintenance treatment.
- Dose induction should aim to achieve an effective dose while also exercising caution about the inherent risks of too rapid an increase. Dose induction with buprenorphine may be carried out more rapidly with less risk of overdose.
- Supervised consumption should be available for all patients for a length of time appropriate to their needs and risks.
- Patients must be made fully aware of the risks of their medication and of the importance of protecting children from accidental ingestion. Prescribing arrangements should also aim to reduce risks to children.
- Clinicians should aim to optimise treatment interventions for patients who are not benefiting from treatment, usually by providing additional and more intensive interventions (pharmacological and psychosocial) that may increase retention and improve outcomes.
- Opioid detoxification, using the medication the patient has been maintained on, should be offered in an appropriate setting to patients ready for and committed to abstinence.
- Methadone, buprenorphine and lofexidine are all effective in detoxification regimens.
- Opioid detoxification should be offered as part of a package including preparation and post-detoxification support to prevent relapse.
- Benzodiazepines prescribed for benzodiazepine dependence should be at the lowest possible dose to control dependence and doses should be reduced as soon as possible.
- There are no effective pharmacological treatments to eliminate the symptoms of withdrawal from stimulants (including cocaine). Psychosocial interventions are the mainstay of treatment.
- Injectable opioid treatment may be suitable for a small minority of patients who have failed in optimised oral treatment.

Chapter 6. Health considerations

- Reducing potential harm due to overdose, blood-borne viruses and other infections should be a part of all patient care.
- All drug misusers should be offered vaccination against hepatitis B and against hepatitis A where indicated.
- All drug misusers should be offered testing and, if required, treatment for hepatitis C and HIV infections.
- Retaining patients in high-quality treatment is protective against overdose. This protection may be enhanced by other interventions including training drug misusers and their families and carers in the risks of overdose, its prevention and how to respond in an emergency.
- Drug misusers who are also misusing alcohol should be offered alcohol treatments.
- Drug misusers who smoke tobacco should be offered smoking cessation interventions.

Chapter 7. Specific treatment situations and populations

- Quality of treatment should be consistent regardless of how patients enter treatment. This includes treatment for those in the criminal justice system, including those in prison.
- Appropriate communication and transfer of information between a wide range of professionals coming into contact with or providing interventions for drug misusers is vital to ensure seamless care.
- Assessment and evidence-based care provided by liaison or a multidisciplinary team is appropriate in many clinical situations, including, for example, with pregnant women, young people, older drug misusers, those with a dual diagnosis, drug misusers with acute and chronic pain, and drug misusers being admitted to or discharged from hospital.
- Clinicians working with pregnant women should strike a balance between reducing the amount of prescribed drugs, in order to reduce fetal withdrawal symptoms, and the risk of the patient returning to or increasing their misuse of illicit drugs.
- Common mental health problems are typical in drug misuse treatment populations. Interventions for these may need to be provided in drug misuse services. Those with severe mental health problems should have high quality, patient-focused care integrated with mental health services.
- Young people are likely to need interventions which are different from those in adults and specific competencies are required to deliver them.
- As drug misusers become older they will have increasing drug-related and non-drug-related health needs.
- Drug misusers in pain will have needs for pharmacological and other interventions similar to non-drug users.
- Drug misusers in hospital will need interventions that facilitate their medical treatment and, if possible, improve their engagement with drug misuse treatment.

Annexes

A1 Doctors' job titles and involvement in treatment
A2 Cardiac assessment and monitoring for methadone prescribing
A3 Writing prescriptions
A4 Travelling abroad with controlled drugs
A5 Interactions
A6 Marketing authorisations
A7 Drugs and driving
A8 Injectable opioid treatment
A9 Policy considerations for under-18s
A10 Useful documents
A11 Contacts

Read the guidelines on **http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/docs/clinical_guidelines_2007.pdf**

2007 Clinical Guidelines – errata

A miscalculation of HIV prevalence figures in section 1.3.2.1 means the percentages quoted are out by a factor of 100. The relevant section should read:

"The overall prevalence of HIV among injecting drug users in England and Wales remains relatively low at 2% (1 in 50) infected but the prevalence in London is much higher at 4% (1 in 25) infected. Of great concern is the recent increase in HIV among IDUs outside London, which has seen a six-fold increase in two years from 0.25% (one in 400) of IDUs in 2003 to 1.5% (one in 65) in 2005."

A personal view of the clinical guidelines on drug dependency 2007

Chris Ford takes us through the 2007 Clinical Guidelines, both celebrating the progress that they will bring, and raising concerns about some areas that she feels may hinder the delivery of drug treatment. She concludes that the 2007 Clinical Guidelines offer great potential for drug users to receive humane and equitable services. Ed.

I would like to give a personal view of the guidelines, picking out a few sections that I would like to celebrate and a few that I feel could have gone further to improve drug treatment. There is much to celebrate in the guidelines for the treatment of people who have drug problems and care has moved a long way since the early '90's but it is my belief that it still has further to go. These guidelines will help to move drug treatment forward, but may in part also hinder.

The guidelines have moved from being for all doctors in 1999 to all clinicians. This is a positive move that acknowledges that a range of people and clinicians are involved in care. The emphasis on multi-disciplinary working reflects what is occurring in the field. However this change causes the guidelines to be much more general and I feel that they lose something because of this. They suffer somewhat from their length and wordiness, although they have been effectively shortened from the draft.

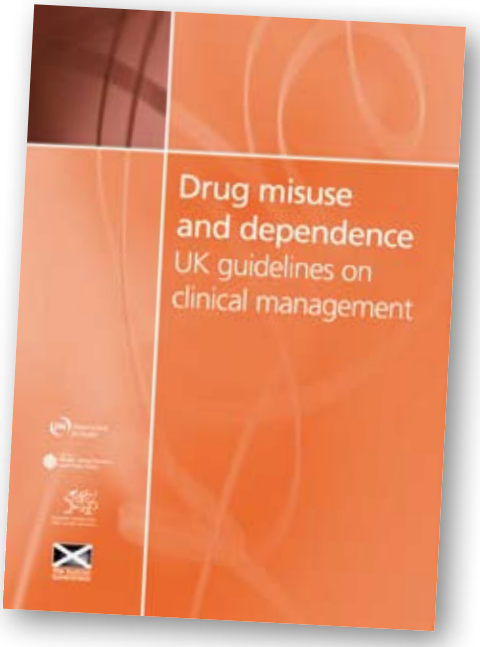
The following statement needs to be celebrated: they

> ***'do not provide rigid protocols on how clinicians must provide drug treatment for all drug misusers. Neither does this guidance override the individual responsibility of clinicians to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient'.***

This for me is such an enormous leap forward, allowing the clinician some professional judgement, but much more importantly placing the patient firmly in the centre of the process.

This theme is further established in chapter 1 'Introduction', and I commend the statement that reads 'It is now more appropriate to stop asking whether treatment for drug misuse is effective, and instead ask how treatment can be improved and how it can be tailored to the needs of different patients'. We also need to celebrate chapter 3 'Essential elements of treatment provision', where the emphasis on comprehensive assessment and assessment of risk firmly establishes that 'drug misuse treatment involves a range of interventions, not just prescribing'. This acknowledges the importance of assessing on-going needs, relapse prevention and the need for speedy access back to treatment if required.

It was great to see chapter 4 'Psychosocial components of treatment' begin with the statement 'Treatment for drug misuse should always involve a psychosocial component'. However, this chapter appears to be trying to be all things to all people and as a result is unclear. It seems to equate keyworking with formal psychological interventions and, perhaps understandably, following the NICE psychosocial guidelines contingency management is recommended. Most of what is described as a 'strong evidence base' for this intervention is from the US, which has a different drug treatment system. However, the fact that the effectiveness of this intervention in the UK is to be 'demonstrated' is to be welcomed.



Chapter 5 'Pharmacological interventions' starts well and there is much to be applauded. The theme of a patient-centred approach and greater flexibility for patients and clinicians is continued. Stating that 'appropriate' maintenance doses for buprenorphine are usually between 12-16mg (and up to 32mg if necessary) is out of line with the NICE technology appraisal which states 12-24 mg (with a maximum of 32mg if necessary). My experience is that many clinicians do not feel a need to prescribe more that 16 mg, but worryingly this mirrors the opinions of many clinicians before the publication of the 1999 guidelines. Typically they said 'my patients do not need more than 40mg of methadone whatever the evidence says'. Recent NTA figures, although improved, still show under-dosing with both methadone and buprenorphine. This recommend maintenance range is likely to perpetuate and entrench the poor use of buprenorphine. I also feel that the section on initiation is confusing, in particular there is not enough clear differential between the entirely different ways to start methadone and buprenorphine. I have no experience of using buprenorphine-naloxone (Suboxone) but there is extensive evidence and experience in the US, Australia and Europe. It is a shame that this evidence was not used, as the guidelines take account of the NICE psychosocial guideline, which is based on US evidence, to underpin the

recommendations regarding contingency management. This omission is probably due to the fact that NICE have examined contingency management but not suboxone.

I was cheered again when the guidelines allowed some clinical freedom around starting doses, depending on the experience and competence of the clinician, and that this theme continued in the section on assessing and responding to progress and failure to benefit. For the first time they look at the full range of improvements that can be made with drug treatment across the range of domains and it is exciting to see written in the guidelines that if a patient isn't benefiting from treatment, that the treatment should be optimised (rather than punishing the patient with the same or reduced doses, or discharging them from treatment). I'm hoping that all advocacy groups will laminate this page, (along with the 'almost never' process of excluding a patient) and send them out to drug services when fighting for that extra 10mg for people!

I am pleasantly surprised about the inclusion of a section on other opiates but am disappointed at the vagueness of the recommendations on injectables. A favourite statement of mine is in the detoxification section 'There is clear evidence that coerced detoxification against a patient's express will is likely to lead to relapse and increased risks of harms such as overdose and blood-borne viruses.'

I feel the benzodiazepines section does not reflect some of the current evidence or the realities of working in general practice. The section lacks references, in particular regarding the reported long-term damage to patients prescribed above 30mg of diazepam. Most of the research for such damage was carried out on small numbers of psychiatric patients and was not undertaken on drug using populations. There are some positive studies that have been done with patients in methadone maintenance treatment; one showing marked reduction in illicit benzodiazepine use in patients on maintenance benzodiazepines compared to those who were tailed off (Weizman 2003) and another study showed reduced injecting (Rosenberg 2002). I am particularly concerned by a 2004 study by Anoro which showed that two risk factors associated with respiratory arrest were prior abstinence from opiates and prior abstinence from benzodiazepines. I feel the possibility exists with the current guidance of recommending detoxification from benzodiazepines, for an increase in the risk of overdose (in a similar way to the risks of overdose posed by the loss of tolerance to opiates). Admittedly there is limited evidence but it may be that neither this possibility nor the wealth of experience in the field both here and abroad has been recognised.

I reached chapter 6 'Health considerations' with excitement, hoping that 'health considerations' was a pseudo-name for harm reduction and it started well with the key points, but for me, there are some problems with this chapter. It is stated that 'Patients should be made aware that a test in general practice may have to be disclosed if they give permission for a medical report for financial purposes, and that confidential test facilities are available, usually in sexual health (GUM) clinics'. I feel this has the potential to undo so much hard work carried out by so many people to normalise the testing for HIV and hepatitis. A third of people with HIV remain undiagnosed and the Chief Medical Officer has recently written a letter to encourage and increase HIV testing in general practice. The figure of a probable 4 out of 5, or 80% of people with hepatitis C being undiagnosed is one of our biggest public health concerns. The wording is confusing 'for financial purposes' – what does this mean? Who is gaining financially? I presume it means for insurance. The correct practice is that if a test is negative then it does not have to be included on insurance requests; if the result is positive then, if it is not revealed when taking out insurance (wherever the test is undertaken), the insurance could be invalid. Consequently the setting, whether general practice or GUM is ultimately unimportant. The investigation and treatment section of hepatitis C, I feel is also confusing and a represents a missed opportunity.

Chapter 7 'Specific treatment situations and populations' starts well with excellent key points. I particularly celebrated the point made that the quality should be the same wherever you enter the system. However, the section on pregnancy does not take into account that there is increasing evidence both that detoxification can be undertaken in early pregnancy with no increased risk (although it may still not be advisable) and that mothers with hepatitis C should generally be encouraged to breast feed. On the positive side the extensive section on parents and child protection, and the sections on older users, pain management and on hospital admission are worthwhile additions.

So how am I left feeling? For me the guidelines seem to range on a continuum from the excellent, through to the disappointing! We still have underdosing of substitute medication for opiate users and I feel the guidelines could have done more to improve that situation. Most of us mainly see poly-drug users and again, there is little guidance for their treatment and the guidelines remain opiate heavy. Benzodiazepines remain the bad guys, but still represent a big problem to the majority of people presenting and there is little guidance for us here.

However we see a true move to patient centred care, increased flexibility for clinicians, a recognition of the importance of multi-agency working and care planning and an understanding of the issues regarding the children of drug users. I'm an optimist and I hope that the excellent sections of these guidelines shine out, all people who have drug problems and who want treatment get treated humanely, have equal and good access to the wide range of services and are given their human rights.

Dr Chris Ford
GP London and SMMGP Clinical Lead

Injectable opioid treatment in the 2007 Clinical Guidelines

Tom Neville discusses the 2007 Clinical Guidelines' approach to injectable opioid treatment, and the effects this is likely to have on service users. Ed.

Whilst unsupervised injectable diamorphine treatment has been part of the British treatment system for decades, guidance regarding this treatment option has not always been clear; this may be partly why the number of people receiving this treatment has been steadily decreasing in the last few years.

In recognition that the clinical guidelines (1999) gave only limited guidance regarding injectable heroin treatment the NTA published guidance on injectable heroin and injectable methadone in 2003, to be implemented alongside the 1999 clinical guidelines [1]. While stating that injectable maintenance treatment needs further research and that there are increased risks in relation to overdose and diversion, the 2003 NTA guidance acknowledges that new evidence has emerged since the 1999 clinical guidelines to support this treatment option.

The new clinical guidelines take their lead from the 2003 NTA guidance. The 2003 NTA guidance clearly states that injectable opioid treatment (IOT) is an effective form of treatment for the minority of clients who have not responded to other (oral) substitution treatment; the new clinical guidelines support this view, clearly stating that injectable diamorphine and injectable methadone are effective treatment options, and that selection of one or the other form of treatment should be made on the basis of assessment of the client, and not on a specified hierarchy. The new guidelines also support the eight principles of treatment that were identified by the working group of the 2003 guidance, and include them as an annex.

The 2003 guidance identified two different groups of patients receiving IOT: those who are newly assessed, and those whom have been in treatment for some time or 'old system' patients. In both cases the new guidelines state providers must encourage the clients not to think of it as a life long treatment, but to encourage people to move towards oral substitution treatment.

The new clinical guidelines make reference to research that suggests that for some 'old system' patients who are already receiving IOT, care planning is not of a very good standard. The guidelines are clear that where poor care planning exists, a client's treatment must not be withdrawn, but must be reviewed more regularly. Where the evidence points to treatment being effective and of benefit to the individual, then this treatment must be continued and improved where possible. It is very clear that those clients in the 'old system' should not have their treatment withdrawn; only if their treatment does not meet their needs should clients be converted to the new system. In all good clinics this change should not be necessary, and clients of these treatment programmes should see little if any change.

For those who are not receiving this treatment at present the guidelines state that treatment should be provided at a local base that has already provided oral methadone maintenance treatment (including adequate doses, and psycho-interventions). All treatment options should have been full explored before any trial of injectable maintenance treatment is offered in a local setting; this should also allow a smooth transition from one treatment to the other and back again if needed. The need for local centres to provide treatment does however provide difficulties for those clients who may be suitable for IOT, but whose local treatment centre does not offer this as an option.

The new guidance advocates supervised consumption for all 'new' patients, and it highlights the need for treatment to be integrated into a wider care planning systems. However it does not state for how long supervised consumption should take place, nor which injectable treatment must be given first. It does give the examples of the Swiss and Dutch models, but only as an example rather than a recommended system. The cost of the treatment plays a vital role in the decision as to whether or not you will receive a specific treatment option; with the cost of supervision this will increase the cost of treatment and may play a key factor in whether this treatment is given at all.

The 2007 clinical guidelines give far clearer guidance regarding IOT than the 1999 clinical guidance, building on the work of the important document produced by the NTA in 2003 (1). The new guidelines support the inclusion of IOT in treatment systems, with appropriate assessment, monitoring and clinical governance. The NTA still recommend that there is need for further work to be done around identifying the most effective models of delivery and also around eligibility criteria.

Tom Neville
Service User Rochdale
SMMGP Member

References

1 National Treatment Agency Injectable heroin (and injectable methadone) Potential roles in drug treatment 2003

Drug misuse and dependence: UK guidelines on clinical management 2007

Stefan Janikiewicz believes that the 2007 Clinical Guidelines will become the text book for practitioners in the drugs field. Whilst there are areas he feels could have been improved, he assesses the new Clinical Guidelines as excellent! Ed.

I have been asked to comment on the recently published guidelines on clinical management (in future referred to as the "*Text Book*" as this is essentially what it will be to most clinicians who work in the field of substance misuse).

Introduction

Overall the *Text Book* enjoys a consensus from all the contributors, and the annexes give some good practical information. I have had the opportunity to work in all of the areas covered and this book acts as a good bench marking tool; this is the new "Gold Standard" and all services should be doing their best to fulfil the criteria to give consistency, i.e. we can all sing from the same hymn sheet.

In the foreword, prescribers should be particularly mindful of the quote: "any clinician not fulfilling the standards and quality of care in the appropriate treatment of drug misusers as set out in these guidelines will have this taken into account, if, for any reason, their performance in this clinical area is assessed". It does not hurt to reinforce accountability to prescribers of controlled drugs.

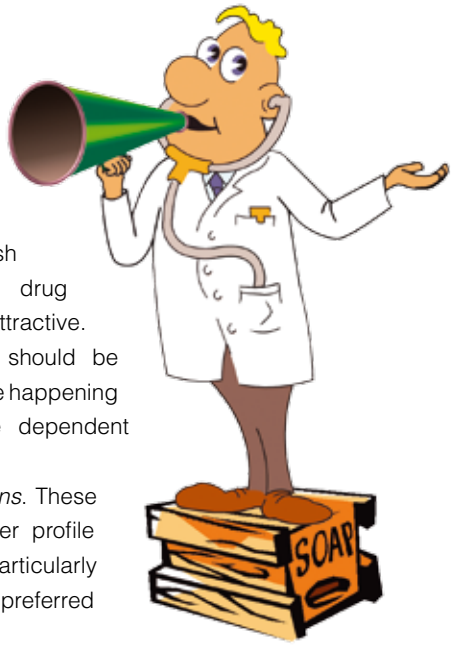
The chapters

A few comments from what were essentially well written sections:

Observed consumption was thankfully questioned as "length of time appropriate in needs and risks". It is important to have this degree of flexibility to allow clients on prescribed medication to 'get on with their lives' whilst receiving drug treatment, rather than an obligatory three months.

The vital pharmacist role I felt was understated as pharmacists usually have more contact with our clients that the prescribing service and can be a valuable information resource.

Children's needs - drug using parents and young people rightly take a much higher profile in this document. If new drug users are changing to alcohol, cannabis, cocaine and ecstasy, then treatment systems must address the needs of this group who perhaps do not perceive they have a problem. Because if, in fact they do wish to present, traditional drug services may seem unattractive. I feel huge emphasis should be placed on what should be happening to children of cocaine dependent parents.



Psychosocial interventions. These now take a much higher profile and are sometimes, particularly for stimulant users, the preferred treatment option.

Benzodiazepines. I would advocate that primary care is not the area for prescribing benzodiazepines, but that it has its place in secondary care.

Pregnancy/ neonatal care. This is a good section and I would hope this is practiced as standard in all areas.

Criminal justice. Much more work still has to be done in the area of the release of prisoners into the community and the establishment of and integrated care pathways to prevent overdose deaths. With the increase in numbers entering custody it is difficult for prisons to cope with prisoners let alone start doing high quality drug work that could change people's lives.

Annexes

We may need a Consultant Cardiologist for the almost 300 people on 100mls of methadone or more, especially if they have to be "closely monitored". The advice about driving and encouraging "second opinions", possibly informing the next of kin and then the DVLA and then the patient themselves should clear the roads of cars overnight. If adhering to this advice, there would be few patients left.

Conclusion

This edition of the clinical guidelines is certainly less regimented than the draft guidelines. However there is little mention of the most vital aspect of all, which is to make sure the patient is treated with dignity. The first few minutes with the keyworker or the prescriber are vital to the success of future management. Competent keyworkers can produce good results with patients.

I would like to have seen a Mission Statement that said "always be kind and firm and set boundaries". Although I could have written a hundred pages in reply, I feel that the overall content of the *Text Book* is excellent and will hopefully make us all work to similar standards to achieve the best outcomes for drug users.

Stefan Janikiewicz
GP and Clinical Director Cheshire & Wirral Partnership NHS Foundation Trust

Commentary on Drug misuse and dependence: UK guidelines on clinical management 2007

Kostas Agath highlights the importance of the 2007 Clinical Guidelines in light of the current policy and practice in the drug treatment field. He describes both positives and areas for development, and he warns that the impressive efforts of the working group will lead to practitioners demanding more! Ed

The 2007 Clinical Guidelines is a very welcome replacement of the 'Drug Misuse and Dependence: Guidelines on Clinical Management' (UK Health Departments, 1999), necessitated by a multitude of factors, including:

a) The progress on the 'Government's 10-Year Strategy for Tackling Drug Misuse' (HMSO, 1998) and the intervening developments in substance misuse service delivery configuration and treatment evidence base.

b) The rising importance of the competency-based rather than the professional qualification-based allocation of role and responsibilities in clinical practice.

c) The increasing need for clinical and organisational risk management in everyday practice.

d) More emphasis on the role of monitoring and regulatory bodies within the NHS.

e) The increasing importance of centrally set key performance indicators in shaping clinical activity within substance misuse treatment settings.

The 2007 Clinical Guidelines offer guidance based on a consensus opinion as well as available evidence, circumventing the problem of extrapolating from addiction research that mostly originates from non-UK based settings. However, the document would have benefited from citing more references to the treatment evidence base.

The 2007 Clinical Guidelines offer very useful advice in many areas a clinician may encounter in everyday practice (i.e. blood borne viruses & bacterial infections; prevention of drug related deaths; drug interactions; writing prescriptions; travelling abroad with controlled drugs; drugs and driving; maternal health; young people). Unfortunately some other areas have relatively short entries, (criminal justice/prisons, pain management, psychiatric comorbidity), missing an opportunity to raise the clinical governance of the management of substance misusers in those diverse settings. Furthermore, some topics have not been addressed at all, including: : equality and diversity; dealing with the poly substance misuser and monitoring a client's progress via the TOP (Treatment Outcomes Profile).

In conclusion, the 2007 Clinical Guidelines offer a very useful encyclopaedic introduction in most areas a clinician needs to be aware of when practicing in UK. The document would benefit from attention to the areas mentioned above. The clinicians working in the diverse drug treatment settings will definitely welcome a revised edition of the Guidelines within the next couple of years. The Herculean efforts of the contributors to the 2007 Guidelines have raised our expectations.

Dr Kostas Agath
Consultant Psychiatrist
Westminster Treatment Centre
Central and North West London NHS Foundation Trust

Here are a few more views on the 2007 Clinical Guidelines. Ed.

Users all over the UK will again welcome a set of guidelines that they can use as a tool to steer their own treatment and to advice others on their treatment options. Many are unaware that guidelines such as these even exist and have never been made aware that there are actually documents out there that prescribers are meant to work to"

Glenda Daniels service manager Oxford User Team

"The right amount of the right drug at the right time and screen, vaccinate and treat for BBVs- it's that simple. If there are any doubts or unresolved issues, then refer the client to an advocate or an organization like the Alliance. I hope these guidelines improve the whole process"

James Grieve
Service user advocate and chair of the National User Network and the conference consortium

"The new guidelines makes a radical change from the foreword which might go unnoticed: the old guidelines were 'for all doctors' the new guidelines are for 'all clinicians'. It was great to see such input from users and carers. I believe this is the first DH document that puts on paper that nurses and pharmacists can now prescribe in this area and it sort of validates the role we have. We have a revised product that is fit for purpose and is easy to read."

Simon Greasley
Clinical Nurse Specialist and non-medical *prescriber*
The Barnsley Primary care clinic

"The guidelines give an overarching view of non-medical prescribing but do not go into detail, which is good because, as the guidelines state, the whole document is for them as well as doctors anyway. On a separate note, official standards and guidance are needed for non-medical prescribers in order to satisfy commissioners, clinical governance leads and other strategic players, otherwise it will not develop properly. Perhaps the respective royal colleges (Pharmacy and Nursing) can be facilitated by the NTA to agree a set of standards and guidance. At the moment it is a bureaucratic nightmare to move non-medical prescribing forward. This was not something that the guidelines could include, I know, but it is vital if the vision is to become a reality"

Jane Haywood
Primary Care Substance Misuse Lead
Qualified (2004) but not practicing non-medical prescriber
Islington PCT

The status of the NICE documentation

Jim Barnard takes us through the status of the various NICE documents and how this may effect their implementation. Ed

NICE publications have an important status within the NHS. Ultimately they are one of the major benchmarks by which our services will be judged. Very simply technology appraisals are a must do. The clinical and public health NICE guidelines must be worked towards, and progress towards them will be monitored and rated. In order for readers to further understand the status, and to emphasise its importance we are giving a slightly more detailed explanation below.

Standards For Better Health

Standards for Better Health (Department of Health 2004) describes the level of quality that health care organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, are expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health. In each of these domains the individual standards fall into two categories:

- ***Core standards:*** which bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect.
- ***Developmental standards*** – which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services which continue to improve in line with increasing patient expectations.

NICE Technology Appraisals

NICE Technology Appraisals are **Core Standards** in **Standards for Better Health.**

Core Standards describe a level of service which is acceptable and which must be universal.

Meeting the core standards is not optional.
Health care organisations must comply with them from the date of publication of Standards for Better Health.

Core Standard C5 states that:

"Health care organisations ensure that they conform to **NICE technology appraisals." The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals.**

The secretary of state has directed that the NHS provides funding and resources for medicines that have been recommended by NICE technology appraisals, normally within 3 months of NICE publishing the guidance.

NICE Clinical Guidelines

NICE Clinical Guidelines are **Developmental Standards** in **Standards for Better Health.**

Developmental Standard D2 states that "Patients receive effective treatment and care that… conform to nationally agreed best practice, particularly as defined in **NICE guidance**,"

"The developmental standards are designed for a world in which patients' expectations are increasing. The levels of investment now being made in the NHS make achievements against these standards realistic. Progress is expected to be made against the developmental standards across much of the NHS as a result of the *NHS Improvement Plan* and the extra investment in the period to 2008. **The Healthcare Commission will, through its criteria for review, assess progress by health care organisations towards achieving the developmental standards."**

It is also worth bearing in mind that it is a **Core Standard (C5)** for Health Care Organisations to take into account nationally agreed guidance when planning and delivering treatment and care, which gives the NICE Guidance and the **2007 Clinical Guidelines** some extra status.

NICE Public Health Intervention Guidance

Developmental standard in Standards for Better Health Standard D13 states "Implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health;" Health care organisations also have a general responsibility to public health and substance misuse in Core Standards 22 and 23.

NTA/Healthcare Commission reviews

The Healthcare Commission and NTA work together to set criteria under which drug treatment services are reviewed annually. These include specific criteria on adherence to elements of national clinical guidelines.

NICE technology appraisal guidance 114: Methadone and buprenorphine for the management of opioid dependency (January 2007)

We have summarised the key points of the NICE technology appraisal for methadone and buprenorphine and given our comments on this welcome addition to the drugs field. Ed.

Main recommendations

1. Methadone and buprenorphine (oral formulations), using flexible dosing regimens, are recommended as options for maintenance therapy in the treatment of opioid dependence.
2. The decision about which drug to use should be made on a case by case basis taking into account a number of factors, including: history of opioid dependence, the patient's commitment to a particular long-term management strategy, and an estimate of the risks and benefits of each treatment made by the responsible clinician. If both drugs are equally suitable, methadone should be prescribed.
3. Both should be administered daily, under supervision, for the first 3 months. Supervision should only be relaxed when compliance is assured. Both drugs should be given as part of a programme of supportive care.

Other points arising

The appraisal points to evidence that the most effective doses of methadone are usually between 60-109 mg and that the adequate maintenance dose of buprenorphine is usually between 12-24 mg. Flexible dosing regimes are emphasised as the most important aspect of maintenance therapy.

SMMGP comment

This document is to be commended in that it gives real status to methadone and buprenorphine as **maintenance** medications. Being recommended by this technology appraisal means that they **MUST** be available in the NHS across the board and they **MUST** also be available at evidence based optimal doses. Even more welcome is the acknowledgement of the importance of flexibility dependent on patient need. In theory patient complaints of underdosing should be a thing of the past as this document, being a technology appraisal, would provide very good grounds for litigation should a service have a ceiling on methadone dosing beneath the optimal range.

Some practitioners have expressed concern regarding the inflexibility around the supervision requirements for methadone dispensing, although the 2007 Clinical Guidelines, which postdates this document, does offer more flexibility, and NICE has confirmed that this greater flexibility is consistent with its own guidance .

Read the appraisal on http://guidance.nice.org.uk/TA114

NICE technology appraisal guidance 115: naltrexone for the management of opioid dependence (January 2007)

We have summarised the main points of the NICE naltrexone technology appraisal and provided some comment upon its likely impact on the drugs field. Ed.

Main Recommendations

1. Naltrexone is recommended as a treatment option in detoxified formerly opioid-dependent people who are **highly motivated** to remain in an abstinence programme.
2. Naltrexone should only be administered under **adequate supervision** to people who have been **fully informed** of the potential adverse effects of treatment. It should be part of a programme of supportive care.
3. The effectiveness of naltrexone in preventing use of opioids should be reviewed regularly. Discontinuation should be considered if there is evidence of opioid use.

Other Points arising

This technology appraisal relates only to naltrexone tablets, as this is the only formulation with a product licence in the UK. Therefore naltrexone implants or depot injections are not subject to this appraisal.

There was a shortage of evidence regarding the cost effectiveness of naltrexone and although research trials have shown a reduction in relapse rates among people treated with naltrexone, there is no similar evidence for retention in treatment. In the end the committee relied quite heavily on professional and expert patient testimony. Adverse effects such as unease (dysphoria), depression and insomnia were noted which could lead to a relapse situation.

SMMGP comment

This appraisal validates the use of naltrexone in aiding relapse prevention. It recognises the importance of the need for patients to be highly motivated, as well as the need for supervision alongside this motivation. The highly debated use if implants (which remove the need for supervision) is not covered and is obviously still an issue for the future. It is useful to have such a clearly delineated rationale for the use of this medication.

Read the appraisal on
http://guidance.nice.org.uk/TA115

Drug Misuse: psychosocial interventions NICE clinical guideline 51 (July 2007)

Contingency management - an innovative new tool for the drugs field, or an expensive and unethical approach? We have summarised key points from perhaps the most controversial document, the NICE clinical guideline on psychosocial interventions and have asked Nat Wright, a NICE guideline development group member, to answer questions and concerns raised by SMMGP members regarding contingency management. Ed.

Key Implementation Priorities

1. Brief Interventions

Opportunistic Brief Interventions should be offered to people in limited contact with drug services (for example those attending a needle exchange scheme or seen in primary care) if concerns about drug misuse are identified. These should normally be 2 sessions of 10-45 minutes and should explore ambivalence about drug use, aiming to increase motivation towards behaviour change, and provide non-judgemental feedback

2. Self Help

Staff should routinely provide people who misuse drugs with information about self help groups. Normally these should be 12 step based groups such as Narcotics Anonymous or Cocaine Anonymous.

3. Contingency management

Drug services should introduce contingency management programmes as part of a phased implementation programme led by the NTA. These programmes should offer incentives, such as vouchers that can be exchanged for goods or services, or privileges such as take home doses of medication contingent on a drug-negative test. The value of such vouchers should start at around £2 and increase with continued abstinence. This approach should also be used to promote physical healthcare such as blood borne virus testing and immunisation with, for example, shopping vouchers up to £10 in value.

The challenge of introducing contingency management into the NHS is acknowledged and the phased implementation will include a series of demonstration sites, whose findings will inform the field. Any implementation programme should include the following elements; agreement with local commissioners regarding changes of contracts or service level agreements, a review of readiness, training programmes for staff, work with service users to raise awareness, and evaluation of the programme.

Other recommendations

The guideline generally endorses good practice in information giving, assessment, and involvement of families and carers. Where the families of people who misuse drugs have not benefited from guided self-help or support groups, staff should consider offering individual family meetings of at least 5 weekly sessions, to

provide information and education, identify sources of stress and explore effective coping mechanisms.

The other formal, drug-specific psychosocial intervention endorsed by the guideline is behavioural couples therapy, which should be considered for people who are in close contact with a non-drug misusing partner. This intervention should focus on the service user's drug misuse and consist of at least 12 weekly sessions.

Evidence-based psychological treatments (in particular, CBT) are recommended for the treatment of comorbid depression and anxiety disorders, in line with existing NICE guidance, for people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment.

In other words CBT and psychodynamic therapy focused on the treatment of drug misuse should not be offered routinely.

To improve concordance with naltrexone treatment contingency management, behavioural couples therapy or behavioural family interventions (as outlined above) are recommended.

Dr Nat Wright replies to a number of questions and issues raised by SMMGP members.

"Given that the only formal psychosocial interventions recommended are contingency management and behavioural couples therapy there seems to be an implication that all other formal interventions should be discontinued."

The guideline states "A range of psychosocial interventions are effective in the treatment of drug misuse; these include contingency management and behavioural couples therapy for drug-specific problems ***and a range of evidence-based psychological interventions, such as*** cognitive behavioural therapy, for common comorbid mental health problems". The remit of NICE is to recommend which clinical and wider health based interventions give the tax paying public most value for money. The guideline does not imply that all other formal interventions should be discontinued. Rather it is highlighting which interventions will give most "bangs per buck" with "bangs" being health gain (usually expressed in terms of "quality of life years") and "buck" being financial investment in health services.

"The evidence which supports contingency management is not from the UK and it may not be culturally congruent with the UK."

The evidence may not be culturally congruent with the UK but the argument works both ways, i.e. it may be. In keeping with most research in the drug dependence field, the bulk of the evidence for contingency management comes from the USA. As the world's richest economy, the USA conducts by far and away the most research into drug dependence and health care generally. It will come as no surprise that Medline, the most internationally recognised electronic database for research abstracts is a US database. Therefore if we were to rely solely on implementing UK based research then we would have much less to implement! However the question of cultural congruence is a valid one which is why a phased rollout will help us to learn any lessons that are specific to the UK drug treatment setting.

"The implementation of this guideline will dramatically change the role of the drug worker."

It probably will, though it does not need to be the drugs worker who administers the vouchers. However change is a necessary component of progress. Almost a century ago the introduction of vaccinations for TB and diphtheria, for example, dramatically changed the role of the GP, but I would argue that our primary consideration should be for the patient. Good drugs workers, as good professionals, will be able to adapt to changes in the field.

"It is difficult to see how this will be rolled out into a primary care setting."

The advantage of contingency management is that compared to many talking therapies it is brief and primary care tends to do brief well! The strength of primary care has always been that it has been a "broad church", and that, as a gatekeeper, it adapts to changing trends in health need. Let's see how the first phase is adapted into primary care.

"The international evidence base seems to be for greater benefit being gained for larger rewards than are being proposed."

The guidance states "If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence". NICE has not stated a ceiling value. Rather behaviour change should be rewarded with increased value of the voucher.

"The interface between contingency management and the benefits system will cause significant problems for many service users."

The level of reimbursement being proposed is unlikely to affect entitlement to benefits. However, if there is a risk of this, then perhaps there will be an army of civil servants looking at the feasibility issues posed by this interface. Contingency management and benefits won't be the first challenge posed to Central Government for "joined up" policy and practice.

"The therapeutic relationship will be compromised by the introduction of a rewards system."

There is no evidence for this but it may be that some services feel more comfortable with a rewards system being administered separately from the professional with whom the user has the strongest therapeutic alliance. Ideally the therapeutic alliance should enhance contingency management and vice versa.

"There will be an unfavourable press reaction to the implementation of this guideline."

It is fair to say that the press reaction has been mixed on this topic but then isn't that the case for most treatment interventions for drug users? For example some sectors of the national and local media persistently question why we offer (for example) needle exchange or methadone maintenance to the "undeserving". The notion of the "deserving" and "undeserving" poor was a view that was prevalent in Victorian times. Sadly, though the issues have changed, the views remain the same in some sectors of society. The bigger challenge for us is how to promote in the media the fact that there are socio-economic determinants that are outside an individual's control, and which increase his or her risk of becoming dependent on drugs.

"Patients will find this approach patronising."

Some patients may find contingency management patronising and clearly contingency management will not be for them. In the same way in which not everyone benefits from methadone maintenance due to a wish to be abstinent, so contingency management is unlikely to be of benefit to all drug users. Contingency management delivered well would, I'd like to think, increase the breadth of interventions available in the drug treatment field.

"The international evidence base seems to be for greater benefit being gained for larger rewards than are being proposed."

The guidance states "If vouchers are used, they should have monetary values that start in the region of £2 and increase with each additional, continuous period of abstinence". NICE has not stated a ceiling value. Rather behaviour change should be rewarded with increased value of the voucher. Whilst there is some evidence for this, the differential gains between higher and lower rewards is not that significant.

Dr Nat Wright
Clinical Director HMP Leeds

Read the guideline on
http://guidance.nice.org.uk/CG51

Drug misuse: opioid detoxification NICE Clinical guideline 52 (July 2007)

Will the detoxification guideline transform the way detoxes are delivered? We have summarised key points from the NICE clinical guideline on opioid detoxification, and have asked Eilish Gilvarry, a NICE guideline development group member, to answer questions and concerns raised by SMMGP members regarding this document. Ed.

Key Implementation priorities

1. Providing information, advice and support

Opioid detoxification should be readily available to patients who have expressed an informed choice. Detailed information should be given regarding detoxification and the associated risks including: the physical and psychological aspects of opioid withdrawal; the use of non-pharmacological approaches; the loss of opioid tolerance following detox and resultant overdose risks; and the importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence after detox.

2. The choice of medication

Methadone and buprenorphine should be first line treatments. In deciding between the two professionals should take into account:

a) Which of the two (if any) medications the patient has been maintained on and utilise that medication for detox

b) The preference of the service user

3. Ultra-rapid detoxification

Ultra-rapid detox under general anaesthesia or heavy sedation (where the airway has to be supported) **must not** be offered, due to the risk of adverse events, including death.

4. The choice of setting

Staff should routinely offer community detox programmes to all patients considering detox. Exceptions may include:

- Where there has been no benefit from previous formal community detox
- Medical/ nursing care is required for significant physical/ mental health problems
- Where complex polydrug detoxification is required
- Where the patient is experiencing complex social problems which will limit the benefit of community detox

Other recommendations

Families and carers support: families and carers should be asked about and be able to discuss the impact of drug misuse on themselves and other family members, they should also be offered an assessment of their personal, social and mental health needs and be provided with:

- Verbal and written information and advice on the impact of drug misuse on users, families and carers
- Information regarding detox and the settings in which it may take place
- Information regarding self-help and support groups for families and carers

Opioid detoxification should not be routinely offered to people:

- With a medical condition requiring urgent treatment
- In police custody, or serving a short prison sentence or a short period of remand: consideration should be given to treating withdrawals with opioid agonist medication for this group
- Who present at an acute emergency setting; the primary emergency problem should be addressed and withdrawal symptoms treated as well as referral to further drug services as appropriate

During pregnancy detox should only be undertaken **with caution.**

With concurrent alcohol dependency, alcohol detoxification should be offered. This should be done **before** opioid detox in a community or prison setting, but may be carried out concurrently in an in-patient setting.

With concurrent benzodiazepine dependency benzodiazepine detoxification should be considered. When deciding whether this is done separately or concurrently the **person's preference** and **severity of dependence** on both substances should be considered.

Lofexidine may be considered for people:

- Who have made an informed and clinically appropriate decision not to use methadone or buprenorphine
- Who have made an informed and clinically appropriate decision to detox in a short time period
- With mild or uncertain dependence (including young people)

Clonidine and **dihydrocodeine** should **not** be routinely used in opioid detox.

The use of **antagonists (e.g naloxone/ naltrexone)** to precipitate withdrawal in ultra-rapid, rapid, and accelerated detox should not be routinely offered.

Residential detoxification (e.g in a residential rehab; for a full definition see NICE guideline) should normally only be considered for people with significant comorbidity or needing multiple detox, but may also be considered for those with less severe dependence or who would benefit significantly from residential rehabilitation.

Contingency management (see the psychosocial guideline) should be considered both during detox and for up to 3-6 months after completion. This will normally be a voucher system starting at £2 in value and increasing with each drug negative test.

Good practice in assessment and adjunctive medications are also discussed in detail.

Duration of detoxification should be up to 4 weeks in an inpatient setting and up to 12 weeks in a community setting.

Dr Eilish Gilvarry replies to a number of questions and issues raised by SMMGP members.

"12 weeks for community detox seems more like a methadone taper than a detoxification. Community detoxification may become inappropriately long."

The guideline refers to "up to 12 weeks" so there is certainly scope for shorter detoxification. NICE determined the upper limit of 12 weeks as being what was used to define detoxification in most of the studies it examined. The 2007 Clinical Guidelines also make reference to even slower rates of reduction agreed with the patient, although these would not be defined as detoxification.

"Many organisations, mostly private, use antagonist medication in the course of detoxification; will this now be expected to stop? Whilst the guideline quotes evidence for adverse events on anaesthesia-assisted detox, similar evidence was not quoted for the use of antagonists in other detoxification methods."

The guideline – and remember it is a guideline – says antagonist treatment "should not be routinely offered" to shorten detoxification. This is because of the risks of adjunctive medication and the increase in the severity of withdrawal symptoms and, when used in the cases of ultra-rapid and rapid detox, requires a high level of nursing and medical supervision. The guideline is much clearer that anaesthesia-assisted detox "must not be offered" and this is because of the risk of serious adverse events.

"The only specific psychosocial intervention recommended is contingency management; the implication seems to be that other psychosocial interventions such as formal relapse prevention sessions should cease."

No, NICE also recommends brief interventions, self-help and behavioural couples therapy. And psychosocial interventions – including relapse prevention – are, of course, embedded in keyworking. This is explained at the beginning of the NICE guideline and in more detail in chapter 4 of the 2007 Clinical Guidelines. However, the evidence for effectiveness and cost-effectiveness that NICE found was strongest for contingency management.

"There is some limited evidence for the efficacy of dihydrocodeine. Will we be missing a further tool for detox if this guideline prevents its use, and what does the term 'not routinely' mean in the context of these guidelines?"

As you say, the guideline says dihydrocodeine "should not be used routinely" which isn't the same as preventing its use. The evidence suggests users are less likely to be abstinent at the end of the detoxification period and no more likely than those on buprenorphine. The guidelines do not stop clinicians using dihydrocodeine but, if used, then it should be within robust clinical governance protocols where clinicians are confident that it is the right treatment and they are competent to deliver it. A specialist opinion may be required where there is any doubt.

"It has been common practice for people on methadone maintenance to be reduced to 30 mg and then transferred to buprenorphine as the latter is often seen as easier to detoxify from. This guideline seems to suggest this practice should cease and people on methadone should detox on methadone."

This is correct - NICE did not find any evidence to support the practice of transfer from one medication to another for the purpose of detoxification. In fact they found that transfer to buprenorphine increased the risk of relapse. However, once again, this is a guideline and, if a patient had a very clear preference to transfer and the clinician supported their preference, it could still be done.

"The emphasis on community detox will reduce completion rates."

NICE makes recommendations on a cost-effectiveness basis and a stepped care approach generally offers the best value for money. So, for most people, starting with community detox makes sense. However, the NICE guideline does allow for inpatient or residential detox in specified cases. And, as in everything with these guidelines, there may be cases when a clinician steps outside the guidelines because of the particular needs and wishes of their patient.

"There is a negativity towards clonidine, however the quoted trials found no significant differences between it and lofexidine; and clonidine is cheaper."

NICE did find a significant difference in the degree of adverse effects (especially hypotension) attributable to clonidine. In addition, clonidine has no marketing authorisation for use in detoxification. If a patient had a very clear preference for clonidine and the clinician felt there were clear and justifiable reasons to step outside the guidelines, clonidine could still be offered, but this would not be routine practice and the risk of side effects would have to be carefully explained to the patient.

Dr Eilish Gilvarry, Clinical Director, Newcastle Drug and Alcohol Unit
Member of the 'Drug Misuse: Opioid Detoxification' Guideline Development Group

Read the guideline on http://guidance.nice.org.uk/CG52

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people: NICE public health intervention guidance 4 (March 2007)

We have summarised the main points of the NICE public health guidance on young people. While it may not directly impact on drug treatment in primary care, it will have an impact on substance misusing young people and their families who are patients of primary care services. Ed.

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people.

Recommendations

1. Local strategic partnerships should implement a strategy for vulnerable and disadvantaged people under 25, as part of a local area agreement.
2. Practitioners should use existing screening and assessment tools, including the NTA's Common Assessment Framework, to identify vulnerable and disadvantaged children. They should also work with specialist stakeholders including parents and carers to provide support and refer on to other services based on a mutually agreed care plan.
3. Practitioners should offer a family based programme of structured support over 2 or more years, drawn up with parents or carers, to children aged 11-16 assessed as being at high risk for substance misuse, and their parents or carers.
4. Practitioners trained in group-based behavioural therapy should offer this intervention over 1-2 years to children, aged 10-12 who are persistently aggressive or disruptive and assessed to be of high risk of substance misuse. They should also offer monthly group based training in parenting skills to their parents or carers over the same period.
5. Practitioners trained in motivational interviewing should offer vulnerable and disadvantaged children, who are problematic substance misusers, one or more motivational interviews.

SMMGP Comment

Though not directly aimed at the adult drug treatment field, vulnerable and disadvantaged young people or their parents and carers will present to primary care on a regular basis, and as a result this guideline is of relevance to primary care practitioners. The interventions recommended are not available on a comprehensive basis in many areas of the country and may prove a considerable challenge to implement.

Read the guideline on
http://guidance.nice.org.uk/PHI4

BULLETIN BOARD

Regional guidance events

The NTA and the National Institute for Health and Clinical Excellence (NICE) are holding a series of one-day events to inform providers, commissioners, service users and carers around the country about important new clinical guidance.

Region	Date
North West	Monday 26 November 2007
North East	Thursday 29 November 2007
Yorkshire and Humber	Friday 30 November 2007
East of England	Monday 3 December 2007
London	Tuesday 4 December 2007
East Midlands	Wednesday 5 December 2007
South East	Tuesday 11 December 2007
South West	Thursday 13 December 2007
West Midlands	Wednesday 23 January 2008

To apply for a place contact your regional NTA Team. Details can be found at **www.nta.nhs.uk**

Tools to support the implementation of NICE Guidance

To support the suite of NICE guidance on the misuse of drugs and other substances, the following implementation tools have been published:

A slide set - to support early awareness-raising activities, highlight key messages from the guidance and make a number of suggestions for its implementation. It can be edited for local use and is available on: http://www.nice.org.uk/guidance/index.jsp?action=download&o=37859

Audit criteria - to assist NHS organisations in monitoring and reviewing their practice against the NICE recommendations and to monitor any subsequent activities. Combined audit criteria have been produced to support the NICE clinical guidelines and public health guidance. Separate criteria have been produced to support the two technology appraisals. The NTA will produce separate audit criteria on the 2007 Clinical Guidelines.

Costing tools/ statements - to help commissioners and finance teams to assess the financial impact of implementing NICE guidance. The spreadsheets provided allow users to estimate the local cost of implementation, taking into account local variation from the national estimates.

All of the above tools are available on the NICE website.

The National Collaborating Centre for Mental Health (NCCMH), which develops the guidance on behalf of NICE, is also producing carer and service user leaflets. NICE, the NCCMH and the National Treatment Agency (NTA) are working together to support the implementation of the NICE drug misuse guidance.

The implementation team at NICE includes a group of implementation consultants who are based throughout England. They do not inspect or publicly report on your current practice. Examples of the support they offer are:

- Helping to raise the profile of NICE guidance with other local organsiations
- Sharing examples of how local organisation have sucessfully worked together to implement guidance
- Providing advice on how to use the implementation support tools

To receive information on the all of the latest implementation tools as well as news and updates from the implementation team at NICE sign up to Into Practice, (hyperlink to: www.nice.org.uk/alerts) a FREE monthly email bulletin for implementers.

Watch out for a commissioning guide for the new clinical guidance, to be developed by the NTA.

NETWORK Production

Editor:
Kate Halliday smmgp@btinternet.com

Advisory Editor:
Dr Chris Ford

Associate Editors:
Jim Barnard
Policy Officer, SMMGP
Jean-Claude Barjolin,
SMMGP Associate

Contact:
SMMGP,
c/o Bolton, Salford and Trafford
Mental Health NHS Trust,
Bury New Road,
Prestwich,
Manchester
M25 3BL

Tel: 0161 772 4641
Fax: 0161 772 3783

email: Kate Halliday
smmgp@btinternet.com

website: www.smmgp.org.uk

Network ISSN 1476-6302

SMMGP works in partnership with

Bolton, Salford and Trafford

NHS
National Treatment Agency for Substance Misuse